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Universal Health Coverage, Priority Setting and the Human Right to Health.

Benedict Rumbold, PhD¹
Rachel Baker, PhD²
Octavio Ferraz, PhD³
Sarah Hawkes, PhD⁴
Carleigh Krubiner, PhD⁵
Peter Littlejohns, MD⁶
Ole Frithjof Norheim, PhD⁷
Thomas Pegram, PhD⁸
Annette Rid, MD⁹
Sridhar Venkatapuram, PhD¹⁰
Alex Voorhoeve, PhD¹¹
Daniel Wang, PhD¹²
Albert Weale, PhD⁸
James Wilson, PhD¹
Alicia Ely Yamin, JD, MPH¹³
Paul Hunt, PhD, MJUR¹⁴

1 Department of Philosophy, University College London

2 Yunus Centre for Social Business and Health, Glasgow Caledonian University

3 The Dickson Poon School of Law, Kings College London

4 Institute for Global Health, University College London

5 Berman Institute of Bioethics, Johns Hopkins University

6 Department of Primary Care and Public Health Sciences, King's College London

7 Department of Global Public Health and Primary Care, University of Bergen and Department of Global Health and Population, Harvard T.H. Chan School of Public Health

8 Department of Political Science, University College London

9 Department of Global Health and Social Medicine, King's College London

10 Department of Global Health and Social Medicine, King's College London and Department of Philosophy, University of Johannesburg

11 Department of Philosophy, Logic and Scientific Method, London School of Economics and Department of Bioethics, U.S. National Institutes of Health

12 School of Law, Queen Mary University of London

13 Georgetown University Law Center and Harvard T.H. Chan School of Public Health

14 School of Law, University of Essex

Corresponding Author:

Dr Benedict Rumbold, Research Fellow, Department of Philosophy, University College London,
Gower Street, London WC1E 6BT, United Kingdom, E-mail: b.rumbold@ucl.ac.uk, Tel: +44 7679
7115

Abstract:

As health policy-makers around the world seek to make progress towards universal health coverage they must navigate between two important ethical imperatives: to set national spending priorities fairly and efficiently; and to safeguard the right to health. These imperatives can conflict, leading some to conclude that rights-based approaches present a disruptive influence on health policy, hindering states' efforts to set priorities fairly and efficiently. Here, we challenge this perception. We argue first that these points of tension stem largely from inadequate interpretations of the aims of priority setting as well as the right to health. We then discuss various ways in which the right to health complements traditional concerns of priority setting and vice versa. Finally, we set out a three-step process by which policy-makers may navigate the ethical and legal considerations at play.

Introduction

Following endorsement by the World Health Organisation (WHO),^{1,2} the World Bank,³ and, most recently, the UN's Sustainable Development Goals,⁴ the drive towards universal health coverage (UHC) is now one of the most prominent global health policies. As countries progress towards UHC, they are forced to make difficult choices about how to prioritise health issues and expenditure: which services to expand first, whom to include first, and how to shift from out-of-pocket payment towards prepayment. Building on an extensive philosophical literature on the ethics of priority setting in healthcare, a recent WHO report provides guidance on how states may resolve these issues.^{5,6} However, policy-makers also face a further question largely left open by the report: where do states' moral and legal obligations regarding the right to health fit in?

This question is pertinent even for countries who have largely achieved UHC.⁷ For example, British policy-makers considering whether to make the UK's commitment to the right to health more explicit in national law would need to consider what effect this would have on existing priority-setting processes in the NHS, including NICE's evaluation of healthcare technologies.

The sceptical position is that these two sets of demands – priority setting and the right to health – are irreconcilable.⁸ Evidence of such tensions might be seen in recent judicial decisions in some Latin American countries, where some courts' defence of what they take to be individuals' rights to expensive new drugs and services have clashed with on-going efforts by national health planners to prioritise expenditures that improve population health.⁹ For

example, in a systematic analysis, Norheim and Wilson found that in Costa Rica less than 3% of the successful cases for medications outside the agreed-upon benefits package would be considered high priority in accordance with standard criteria of clinical effectiveness, cost-effectiveness, severity of disease and strength of evidence. By contrast, more than 70% of the court-mandated provisions concerned medications judged to be of low priority.¹⁰

Such cases may lead to the perception that a rights-based approach to health policy necessarily presents a disruptive influence on states' efforts to set priorities fairly and efficiently. In this article we reject this view. When properly interpreted, there are ways in which the right to health can aid priority setting and, conversely, in which fair priority setting is essential to the realisation of the right to health.

The limited justification for the sceptic's worries

It is important to acknowledge that there are ways in which one could interpret both what constitutes a just distribution of health care resources and what constitutes the human right to health which could lead the two imperatives to pull in separate directions. That is, if one were to equate 'priority setting' simply with a utilitarian drive to maximize health benefits across a given population, and the 'right to health' as simply the claim that all individuals ought to have access to any medical treatment they might need regardless of cost, then the two imperatives would clearly conflict. Indeed, where we find that there has been a conflict between these imperatives – such as in respect to some of the cases in Latin America – it has been as a result of precisely these kinds of inadequate interpretations.

However, there is little in the philosophical and legal literature or international law to justify such readings, and they are increasingly out of step with judicial practice.^{11,12} First, philosophers have long argued that achieving justice in healthcare priority setting involves applying a range of substantive ethical principles beyond utilitarian calculations of which policies maximize health.^{5,13,14,15,16,17} In addition, both philosophical discussion and legal theory are moving away from seeking to determine health policy priorities through an appeal to particular substantive principles alone, instead looking to ensure just distribution through a fair and accountable process.^{11,18,19,20}

The notion that the right to health means that an individual has a claim against the state to any medical treatment they need, regardless of cost, also fails to reflect current philosophical thinking,²¹ not to mention being plainly inconsistent with the ordinary and natural reading of international human rights law. For example, according to article 2(1) of

the International Covenant on Economic, Social and Cultural Rights (ICESCR) the rights in the covenant, including the right to health, are subject to both progressive realisation and resource availability.²² General Comment 14, arguably an authoritative interpretation of the ICESCR, goes further, requiring that, under resource constraints, trade-offs between ensuring effective interventions – including between health care, public health policies and tackling the social determinants of health – are made fairly:

With respect to the right to health, equality of access to health care and health services has to be emphasized... Inappropriate health resource allocation can lead to discrimination that may not be overt. For example, investments should not disproportionately favour expensive curative health services which are often accessible only to a small, privileged fraction of the population, rather than primary and preventive health care benefiting a far larger part of the population.²³

How rights concepts can aid priority setting

Far from being disruptive, there are various ways in which the right to health, properly understood, can help priority setting. First, the notion that all human beings have a right to health by virtue of being human can establish a moral foundation for why prioritisation needs to occur.^{24,25} In articulating the problem of priority setting, academic writers – especially health economists – often describe the dilemma as one that manifests in the committee room: actors must decide how to allocate resources across different populations under conditions of scarcity.²⁶ The right to health, though, helps to explain how we got to the committee room in the first place: that is, each individual, by virtue of being human, has a right to health. The committee is brought together to respond to those moral (and legal) claims, showing equal concern for each individual.

Second, rights can provide a powerful framework for dealing with issues of discrimination, exclusion and power asymmetries, establishing the normative significance of many of the moral principles appealed to in priority setting. Importantly, ‘rights talk’ forces attention on issues of equity. Thus, if priority setters were, misguidedly, to seek only a utilitarian maximization of population health, then rights would provide normative and legal resources for a critique.

Third, rights offer an important mechanism for citizens and health planners to petition for additional resources and for the health service to actually deliver on services already established as high priority. In this way, litigation under the right to health can be a mechanism by which health systems are prompted to deliver the services they should be providing,²⁷ rather than services they should not (such as in some of the cases from Latin America cited earlier).^{9,10}

Following this last point, it should also be noted that the language and strictures of rights emphasizes citizens' role as agents, who are entitled to influence priority setting and to hold decision-makers to account.¹⁹

Ways in which the realisation of the right to health relies on good priority setting

Interpreted correctly, priority setting is also integral to realisation of the right to health. First, as noted above, aspects of international law regarding the right to health *require* policy-makers to prioritise between different services and treatments.

While not a feature of all conceptions of the right to health, international human rights law also demands the fulfilment of certain 'core obligations' with respect to the right to health, one of which is a requirement that states devise national strategies and plans of action based upon the burden of disease across the entire population through a legitimate and participatory process.²³ In other words, it requires a fair and accountable priority setting process.

Recommendations for policy makers

In sum, efforts to uphold individuals' right to health and to set priorities in the health care system have a common grounding and can be mutually dependent and mutually reinforcing. For states with the necessary civil institutions in place, we offer the following three-step process by which decision makers can reconcile these imperatives on the path towards UHC.

First, those responsible for advising on or ensuring a fair allocation of health-care resources (e.g. priority setters, local and national health planners) as well as those charged with upholding the right to health (e.g. legislators, judges), need to recognize broader and more recent interpretations of each imperative. Priority setting is not only about a utilitarian drive to maximize health benefits across the population nor is the right to health about securing every individual's access to health care regardless of cost.

Second, once substantive and procedural principles for ensuring fair allocation of resources devoted to health have been decided through a transparent and participatory process, states need to institutionalize priority setting. This could include an organization for systematic assessment of new and existing health technologies as well as an advisory panel for wider questions of allocative efficiency and fairness, and action on the social, economic and political determinants of health. Such bodies must be accountable to their populations, government and the judiciary. Ensuring the proper functioning of these bodies should be recognised as one way in which states contribute to the implementation of the right to health.

Third, once an acceptable interpretation of the content of the right to health under national law has been clarified, respecting the principles discussed above, finance ministers should reappraise their budgets in light of the state's obligations under that right. The right to health, just as civil and political rights, requires resources of various kinds, whether through taxation or other means. As with civil and political rights, the right to health is supposed to have teeth. When the *status quo* fails to uphold people's rights, changes, including judicial remedies, are needed.

Conclusion

As they progress towards the achievement of UHC, policy-makers around the world face two ethical imperatives: to set national spending priorities fairly and efficiently; and to safeguard the right to health. Under certain, inadequate interpretations, these aims can appear to conflict. However, understood properly, there are a number of ways in which priority setting and the right to health are mutually supportive. As well as highlighting these points of convergence, in this article we have set out a three-step process for establishing policies and procedures that progressively realize people's right to health and set fair priorities.

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Author Contributions

The argument presented in this paper represents the collective and equal effort of all the named authors, the paper itself being the result of a workshop on the issue attended by all parties. Benedict Rumbold was responsible for drawing up a first draft of the article and handling subsequent edits. Paul Hunt worked closely in an advisory capacity, reflected in his position as last author. All other authors provided comments and suggested edits throughout the drafting process, their equal contributions reflected in the listing of their names in A-Z order. The opinions expressed are the view of the authors only. They do not represent any position or policy of the U.S. National Institutes of Health, the Public Health Service, or the Department of Health and Human Services.

Declaration of Interests

There are no conflicts of interest

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